HOUSE BILL No. 6240

June 8, 2010, Introduced by Reps. Corriveau and Ball and referred to the Committee on Health Policy.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3406f, 3503, and 3539 (MCL 500.3406f, 500.3503, and 500.3539), section 3406f as added by 1996 PA 517, section 3503 as amended by 2006 PA 366, and section 3539 as amended by 2005 PA 306, and by adding chapter 37A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3406f. (1) ~~An~~ **EXCEPT AS OTHERWISE PROVIDED IN SECTION 3763, AN** insurer may exclude or limit coverage for a condition as follows:

(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates

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to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(b) For an individual covered under a group policy or certificate covering 2 to 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(c) For an individual covered under a group policy or certificate covering more than 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

(2) As used in this section, "group" means a group health plan as defined in ~~section 2791(a)(1) and (2) of part C of title XXVII of the public health service act, chapter 373, 110 Stat. 1972, 42 U.S.C. 300gg-91~~ **42 USC 300GG-91**, and includes government plans that are not federal government plans.

(3) This section applies only to an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate. This section

does not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, or 1-time limited duration policy or certificate of no longer than 6 months.

~~(4) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by preexisting condition limitations or exclusions under subsection (1)(a), (b), and (c) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:~~

~~(a) Cost of crediting prior continuous health care coverages.~~

~~(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.~~

~~(c) Types and scope of prior health care coverages that are permitted to be credited.~~

~~(d) Any exceptions or exclusions to crediting prior health care coverage.~~

~~(e) Uniform method of certifying periods of prior creditable coverage.~~

Sec. 3503. (1) All of the provisions of this act that apply to

a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, sections 223 and 7925 and chapters 34**,** ~~and~~ 36, **AND 37A** apply to a health maintenance organization under this chapter unless specifically excluded, or otherwise specifically provided for in this chapter.

(2) Sections 408, 410, 411, 901, and 5208, chapter 77, and, except as otherwise provided in subsection (1), chapter 79 do not apply to a health maintenance organization.

Sec. 3539. (1) ~~For~~ **EXCEPT AS OTHERWISE PROVIDED IN SECTION 3763, FOR** an individual covered under a nongroup contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.

(2) A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract **OR AS PROVIDED IN SECTION 3763**.

(3) Except as provided in subsection (5), a health maintenance organization that has issued a nongroup contract shall renew or continue in force the contract at the option of the individual.

(4) Except as provided in subsection (5), a health maintenance organization that has issued a group contract shall renew or continue in force the contract at the option of the sponsor of the

plan.

(5) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(6) A health maintenance organization is not required to continue a healthy lifestyle program or to continue any incentive associated with a healthy lifestyle program, including, but not limited to, goods, vouchers, or equipment.

(7) As used in this section, "group" means a group of 2 or more subscribers.

CHAPTER 37A

HEALTH BENEFIT PLANS

SEC. 3751. AS USED IN THIS CHAPTER:

(A) "CARRIER" MEANS A PERSON THAT PROVIDES HEALTH BENEFITS, COVERAGE, OR INSURANCE UNDER A HEALTH BENEFIT PLAN IN THIS STATE. FOR THE PURPOSES OF THIS CHAPTER, CARRIER INCLUDES A HEALTH INSURANCE COMPANY AUTHORIZED TO DO BUSINESS IN THIS STATE, A HEALTH CARE CORPORATION, A HEALTH MAINTENANCE ORGANIZATION, A MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR ANY OTHER PERSON PROVIDING A PLAN OF HEALTH BENEFITS, COVERAGE, OR INSURANCE SUBJECT TO STATE INSURANCE REGULATION.

(B) "ENROLLEE" MEANS AN INSURED, ENROLLEE, MEMBER, PARTICIPANT, OR SUBSCRIBER UNDER A HEALTH BENEFIT PLAN.

(C) "HEALTH BENEFIT PLAN" OR "PLAN" MEANS A GROUP, INDIVIDUAL, OR NONGROUP EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY

OR CERTIFICATE, HEALTH CARE CORPORATION CERTIFICATE, OR HEALTH MAINTENANCE ORGANIZATION CONTRACT. HEALTH BENEFIT PLAN DOES NOT INCLUDE ACCIDENT-ONLY, CREDIT, OR DISABILITY INCOME INSURANCE; LONG-TERM CARE INSURANCE; MEDICARE SUPPLMENTAL COVERAGE; COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE; COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS; DENTAL-ONLY OR VISION-ONLY INSURANCE; WORKER'S COMPENSATION OR SIMILAR INSURANCE; OR AUTOMOBILE MEDICAL-PAYMENT INSURANCE.

(D) "HEALTH CARE CORPORATION" MEANS A NONPROFIT HEALTH CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704.

(E) "PATIENT PROTECTION AND AFFORDABLE CARE ACT" MEANS THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148.

(F) "SECRETARY" MEANS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

SEC. 3755. (1) A CARRIER SHALL NOT ESTABLISH LIFETIME LIMITS OR UNREASONABLE ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR AN ENROLLEE, OTHER THAN AS PERMITTED IN SECTION 2711 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

(2) SUBSECTION (1) DOES NOT PREVENT A CARRIER THAT IS NOT REQUIRED TO PROVIDE ESSENTIAL HEALTH BENEFITS UNDER SECTION 1302(B) OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT FROM PLACING LIFETIME LIMITS OR ANNUAL LIMITS PER INSURED, ENROLLEE, MEMBER, OR PARTICIPANT ON SPECIFIC COVERED BENEFITS TO THE EXTENT THAT THOSE LIMITS ARE OTHERWISE PERMITTED UNDER FEDERAL OR STATE LAW.

SEC. 3757. (1) A CARRIER SHALL NOT RESCIND A HEALTH BENEFIT PLAN FOR AN INDIVIDUAL ONCE THE INDIVIDUAL IS COVERED UNDER THE

HEALTH BENEFIT PLAN.

(2) SUBSECTION (1) DOES NOT APPLY TO A COVERED INDIVIDUAL WHO HAS COMMITTED AN ACT OR PRACTICE THAT CONSTITUTES FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT. A HEALTH BENEFIT PLAN SHALL NOT BE RESCINDED WITHOUT PRIOR NOTICE TO THE COVERED INDIVIDUAL AND ONLY AS PERMITTED UNDER SECTION 2702(C) OR 2742(B) OF THE PUBLIC HEALTH SERVICE ACT, 42 USC 300GG-1 AND 400 USC 300GG-42.

SEC. 3759. (1) A CARRIER SHALL, AT A MINIMUM, PROVIDE FOR AND NOT IMPOSE ANY COST SHARING REQUIREMENTS ON ALL OF THE FOLLOWING:

(A) EVIDENCE-BASED ITEMS OR SERVICES THAT HAVE IN EFFECT A RATING OF "A" OR "B" IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE.

(B) IMMUNIZATIONS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR THE INDIVIDUAL INVOLVED.

(C) FOR INFANTS, CHILDREN, AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR PURPOSES OF THIS SECTION.

(D) FOR WOMEN, ANY ADDITIONAL PREVENTIVE CARE AND SCREENINGS NOT DESCRIBED IN SUBDIVISION (A) AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR PURPOSES OF THIS SECTION.

(2) AS USED IN THIS SECTION, THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE CONCERNING BREAST CANCER SCREENING, MAMMOGRAPHY, AND PREVENTION SHALL BE CONSIDERED

THE MOST CURRENT OTHER THAN THOSE ISSUED AROUND NOVEMBER 2009.

(3) THIS SECTION DOES NOT PROHIBIT A CARRIER FROM PROVIDING A HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE FOR SERVICES IN ADDITION TO THOSE RECOMMENDED BY, OR THAT DENIES COVERAGE FOR SERVICES THAT ARE NOT RECOMMENDED BY, THE UNITED STATES PREVENTIVE SERVICES TASK FORCE.

SEC. 3761. A HEALTH BENEFIT PLAN THAT PROVIDES FOR DEPENDENT COVERAGE SHALL PERMIT CONTINUATION OF THAT COVERAGE UNTIL THAT CHILD ATTAINS AGE 26 AS PROVIDED IN SECTION 2714 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND REGULATIONS PROMULGATED UNDER THAT SECTION. THIS CONTINUATION OF COVERAGE DOES NOT APPLY TO ANY CHILD OF A CHILD RECEIVING DEPENDENT COVERAGE UNDER THIS SECTION.

SEC. 3763. A CARRIER SHALL NOT DENY A CHILD WHO IS UNDER 19 YEARS OF AGE ACCESS TO HIS OR HER PARENT'S HEALTH BENEFIT PLAN AND SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION OR LIMITATION ON THE CHILD'S COVERAGE.

SEC. 3765. BY NOT LATER THAN 60 DAYS BEFORE A HEALTH BENEFIT PLAN PREMIUM INCREASE GOES INTO EFFECT, A CARRIER SHALL SUBMIT TO THE COMMISSIONER NOTICE OF, AND JUSTIFICATION FOR, THE PREMIUM INCREASE. THE CARRIER SHALL ALSO PROMINENTLY PUBLISH THE NOTICE OF, AND JUSTIFICATION FOR, THE PREMIUM INCREASE ON THE CARRIER'S INTERNET WEBSITE.

SEC. 3767. (1) A CARRIER SHALL SUBMIT TO THE SECRETARY AND THE COMMISSIONER A REPORT EACH CALENDAR YEAR ON THE RATIO OF THE INCURRED LOSS OR INCURRED CLAIMS PLUS THE LOSS ADJUSTMENT EXPENSE OR CHANGE IN CONTRACT RESERVES TO EARNED PREMIUMS. THE REPORT SHALL

INCLUDE THE PERCENTAGE OF TOTAL PREMIUM REVENUE, AFTER ACCOUNTING FOR COLLECTIONS OR RECEIPTS FOR RISK ADJUSTMENT AND RISK CORRIDORS AND PAYMENTS OF REINSURANCE, THAT SUCH COVERAGE EXPENDS ON ALL OF THE FOLLOWING:

(A) REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES UNDER THE COVERAGE.

(B) ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY.

(C) ALL OTHER NONCLAIMS COSTS, INCLUDING AN EXPLANATION OF THE NATURE OF THE COSTS, AND EXCLUDING FEDERAL AND STATE TAXES AND LICENSING OR REGULATORY FEES.

(2) BEGINNING JANUARY 1, 2011, A CARRIER SHALL PROVIDE A REBATE PURSUANT TO SUBSECTION (3) IF THE RATIO OF THE PREMIUM REVENUE EXPENDED BY A CARRIER ON COSTS DESCRIBED IN SUBSECTION (1)(A) AND (B) TO THE TOTAL AMOUNT OF PREMIUM REVENUE, EXCLUDING FEDERAL AND STATE TAXES AND LICENSING OR REGULATORY FEES AND AFTER ACCOUNTING FOR PAYMENTS OR RECEIPTS FOR RISK ADJUSTMENT, RISK CORRIDORS, AND REINSURANCE UNDER SECTIONS 1341, 1342, AND 1343 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, FOR THE HEALTH BENEFIT PLAN YEAR IS LESS THAN THE FOLLOWING:

(A) FOR A LARGE GROUP HEALTH BENEFIT PLAN, 85%.

(B) FOR A SMALL GROUP HEALTH BENEFIT PLAN OR INDIVIDUAL HEALTH BENEFIT PLAN, 80%.

(3) BEGINNING JANUARY 1, 2011, REBATES SHALL BE PROVIDED ANNUALLY, ON A PRO RATA BASIS, TO EACH ENROLLEE COVERED UNDER A HEALTH BENEFIT PLAN FOR THE COVERAGE YEAR IN WHICH THE PLAN DID NOT MEET THE RATIO DESCRIBED IN SUBSECTION (2). THE TOTAL AMOUNT OF AN ANNUAL REBATE SHALL BE IN AN AMOUNT EQUAL TO THE PRODUCT OF THE

AMOUNT BY WHICH THE PERCENTAGE IN SUBSECTION (2)(A) OR (B) EXCEEDS THE RATIO DESCRIBED IN THAT SUBSECTION AND THE TOTAL AMOUNT OF PREMIUM REVENUE, EXCLUDING FEDERAL AND STATE TAXES AND LICENSING OR REGULATORY FEES AND AFTER ACCOUNTING FOR PAYMENTS OR RECEIPTS FOR RISK ADJUSTMENT, RISK CORRIDORS, AND REINSURANCE UNDER SECTIONS 1341, 1342, AND 1343 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, FOR THAT PLAN YEAR.

Enacting section 1. This amendatory act takes effect September 23, 2010.

Enacting section 2. Sections 3755, 3757, and 3761 apply to health care benefit plans in existence on September 23, 2010 beginning on the plans' next renewal date after September 23, 2010.

Enacting section 3. This amendatory act does not take effect unless Senate Bill No.____ or House Bill No. 6241(request no. 06726'10) of the 95th Legislature is enacted into law.